



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Respondent Name

ZURICH AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-07-1418-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "To determine fair & reasonable we use the Med Par Data, APC Rates, CMS fee schedules for Lab, Drugs and DMEPOS. Therefore, a fair and reasonable reimbursement on this patient would be \$17,110.23... Therefore, using our methodology, we should be reimbursed \$14326.13 + implants at \$2784.10 = \$ 17,110.23. The implants should be paid at cost + 10%. Using our methodology, which has been explained we feel our reimbursement should be \$17,110.23... The Commission has clearly stated that a carrier, in a DOP situation, cannot establish a 'one size fits all' rate reimbursement. Rather, the methodology used must calculate a rate of reimbursement that is case specific. In this case, the carrier has not submitted any case specific analysis or methodology to justify its rate of reimbursement. As such, Renaissance hospital should be reimbursed at its usual and customary rate per Texas Labor Code Sec. (413.011(b))."

Amount in Dispute: \$34,030.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2005	Outpatient Services	\$34,030.78	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes
2. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, requires that “Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers’ Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on November 6, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 16, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. U.S. Bankruptcy Judge Michael Lynn issued a “STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS,” dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the Workers’ Compensation Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor’s estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer’s behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W10 – No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
 - (850-054) – THE RECOMMENDED PAYMENTS ABOVE REFLECT A FAIR, REASONABLE AND CONSISTENT METHODOLOGY OR REIMBURSEMENT PURSUANT TO THE CRITERIA SET FORTH IN SECTION 413.011(D) OF THE TEXAS WORKERS’ COMPENSATION ACT.
 - M – NO MAR \$0.00
 - M – NO MAR \$1,100.00
 - M – NO MAR \$3,828.00
 - 45 – [No description of this code was found in the submitted information.]
 - 57 – [No description of this code was found in the submitted information.]
 - 303 – [No description of this code was found in the submitted information.]
 - 50 – [No description of this code was found in the submitted information.]
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
 - (920-002) – IN RESPONSE TO A PROVIDER INQUIRY, WE HAVE RE-ANALYZED THIS BILL AND ARRIVED AT THE SAME RECOMMENDED ALLOWANCE.

Findings

1. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the submitted documentation finds that the requestor did not state how the submitted documentation supports the requestor’s position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
2. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the submitted documentation finds that:
 - The requestor’s position statement asserts that “To determine fair & reasonable we use the Med Par Data, APC Rates, CMS fee schedules for Lab, Drugs and DMEPOS. Therefore, a fair and reasonable

reimbursement on this patient would be \$17,110.23... Therefore, using our methodology, we should be reimbursed \$14326.13 + implants at \$2784.10 = \$ 17,110.23. The implants should be paid at cost + 10%. Using our methodology, which has been explained we feel our reimbursement should be \$17,110.23..."

- The requestor did not sufficiently explain the proposed methodology or demonstrate how the requested reimbursement amount for the base rate of \$14326.13 was calculated.
- The requestor did not provide documentation of the Med Par Data, APC Rates, CMS fee schedules for Lab, Drugs and DMEPOS or other data to support the proposed methodology.
- The requestor did not explain or submit documentation to support that paying the implants at cost + 10% would provide a fair and reasonable reimbursement for the implants.
- The requestor's position statement further asserts that "...Renaissance hospital should be reimbursed at its usual and customary rate per Texas Labor Code Sec. (413.011(b))."
- The requestor did not explain or submit documentation to support how payment of the usual and customary charges would result in a fair and reasonable reimbursement for the services in dispute.
- The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges..." 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rule at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

Authorized Signature

_____	<u>Grayson Richardson</u>	<u>February 29, 2012</u>
Signature	Medical Fee Dispute Resolution Officer	Date

_____	_____	_____
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.